

**EXHIBIT R**

ADJUDICATOR: S. Cook

CLAIMANT NAME: ARTHUR JACKSON III  
SSN: 203-42-8537DAILY ACTIVITIES QUESTIONNAIRE

PLEASE COMPLETE THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY. PLEASE EXPLAIN YOUR ANSWERS WHENEVER POSSIBLE BY GIVING DESCRIPTIONS AND EXAMPLES. COMPLETE THE QUESTIONS ACCORDING TO WHAT YOU DO MOST DAYS. YOUR COOPERATION IS APPRECIATED.

GENERAL INFORMATION:

1. Where do you currently live?  
Home \_\_\_\_\_ Apartment \_\_\_\_\_ Boarding House \_\_\_\_\_  
Nursing Home \_\_\_\_\_ Other X WITH FRIEND
2. Do you live alone? Yes \_\_\_\_\_ No X  
If no, who lives with you?  
CAMILA MCFARREN + HER TWO CHILDREN

SECTION I:

1. What do you do on a TYPICAL day from the time you wake up until going to bed?  
GET UP TAKE SHOWER AND GO DOWN STAIRS  
+ WATCH TV EAT DINNER + GO TO BED

How have these activities changed because of your condition?

? HAVE NOT CHANGED

2. Do you need any special help or reminders to take care of your personal needs (washing, bathing, shaving, dressing, etc.)?  
Yes X No \_\_\_\_\_  
If yes, PLEASE DESCRIBE.

REMINING ME TO CHANGE MY CLOTHES  
DAILY, AND BATHE



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3. Do you clean your home? NO  
If yes, what type of things are done?  
If no, what type of help is needed?  
CAMILLA MCFADDEN DOES IT + KIDS HELP HER OUT  
AND THEY DO MOST OF THE WORK
4. Do you do your own shopping? NO  
If yes, do you buy appropriate items and get correct change?  
If no, what type of help is needed?  
ONE OF MY NEIGHBORS DO IT FOR ME OR IT  
IS DELIVERED
5. Do you prepare meals?  
If yes, what kinds of foods are made? YES  
If no, what type of help is needed?  
MICROWAVE
6. Do you drive a car? Yes X No X  
Can you take a bus/train/cab alone? Yes \_\_\_\_\_ No X  
If no, why?  
CANNOT BE LEFT STANDING, LACK OF CONCENTRATION  
+ GET LOST
7. Can you handle your own bills? Yes \_\_\_\_\_ No X  
If no, why? MAJOR DEPRESSION SOMETIMES I JUST CANT DO IT.

SECTION II

1. Do you have any problems getting along with family, friends, neighbors, etc.? Yes X No \_\_\_\_\_  
If yes, explain and GIVE EXAMPLES.  
ANGER, CANT GET OUT OF BED SOMETIMES BECAUSE  
I DONT WANT TO SEE ANYBODY.
2. Describe what kinds of activities you participate in with relatives, friends, etc.  
NONE

How often do you participate in these activities?



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3. How well do you get along with people in authority (doctors, supervisors, police officers, etc.)? PLEASE EXPLAIN. WHEN  
AT TIMES I DO WELL BUT I AM NOT RESPONDING WELL TO MY MEDICATION THEN I HAVE PROBLEMS.

4. How well do you respond to criticism? PLEASE EXPLAIN.  
SAME, SOMETIMES OK. BUT I WILL LASH OUT.

5. Do you have any difficulty when you go out in public?  
Yes X No \_\_\_\_\_  
If yes, PLEASE DESCRIBE.

I AVOID IT PANIC ATTACKS

6. Do you belong to any groups or clubs? Yes \_\_\_\_\_ No X  
If yes, PLEASE DESCRIBE.

7. Have you ever been in fights, evicted, fired, etc.? Yes X No \_\_\_\_\_  
If yes, PLEASE DESCRIBE.

ANGER, CONFUSION, RAGE, HATE - I HATE MYSELF  
HAVE NO DISCIPLINE FOR MYSELFSECTION III

1. Do you have any hobbies or interests? Yes \_\_\_\_\_ No X  
If yes, PLEASE DESCRIBE.

2. Are you able to start and complete projects or activities such as, reading a book, putting a puzzle together, sewing/needlepoint, fixing things around the house, etc.? Yes \_\_\_\_\_ No X  
PLEASE DESCRIBE AND GIVE EXAMPLES.

I start but forget where I was in the project or loose interest



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3. Are you able to plan each day such as, when to get up, start meals, finish household chores, go to appointments, etc.? Yes \_\_\_\_\_ No X  
If no, GIVE EXAMPLES.

I CAN GET UP ON MY OWN, BUT NOW AFTER THIS DEPRESSION SOMEONE HAS TO PUT IT ON THE CALENDAR FOR ME.

4. Do you have trouble following instructions and carrying them out? Yes X No \_\_\_\_\_  
If yes, GIVE EXAMPLES.

LACK OF CONCENTRATION, I START ONE THING THEN DO SOMETHING ELSE

**SECTION IV**

1. What happens when you are faced with changes such as, change in daily schedule, change in living arrangements, change in doctors etc.?  
ANGER, I GET STRESSED THEN NOTHING HAPPENS BECAUSE I JUST LEAVE

2. What happens when you have a disagreement with someone?  
DEPENDS ON HOW I AM RESPONDING TO MEDICATION  
COULD END UP IN FIGHT

3. Can you make decisions on your own? Yes / No /  
If no, who helps you make decisions?

MY FRIEND

4. Do you take medication for your condition? Yes X No \_\_\_\_\_  
Please list the medicine and amounts.

DESYREL 100 mg 1-2 AT BEDTIME

EFFEXOR 75 mg 2x DAILY

KLONOPIN 1 mg. 2x " 2 AT BEDTIME

PROCARDIA 30 mg 1x "

PEPCID 20mg 1x

NAPROXIN

SEE BACK →

5. Do you need help taking medication? Yes / No /  
If yes, who helps you?

MY FRIEND

CANT REMEMBER IF ALL HAS BEEN TAKEN  
SO SHE CHECKS FOR ME



ADJUDICATOR: S. Cook

CLAIMANT NAME: ARTHUR JACKSON III  
SSN: 203-42-8537SECTION VIF YOU WORKED IN THE PAST, PLEASE COMPLETE THE FOLLOWING QUESTIONS:

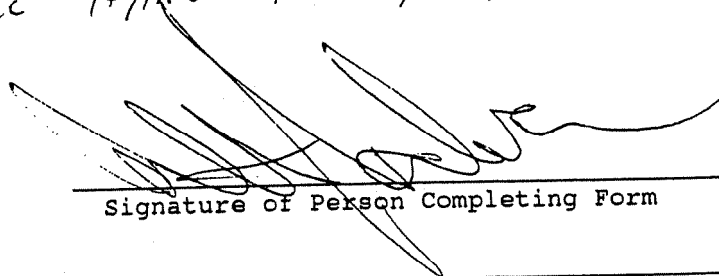
1. Did you usually report to work on time? Yes X No \_\_\_\_\_  
If no, PLEASE DESCRIBE.
2. Did you have good attendance? Yes X No \_\_\_\_\_  
If no, PLEASE DESCRIBE.
3. Were you usually able to keep up with your work? Yes X No \_\_\_\_\_  
If no, PLEASE DESCRIBE.
4. Were you able to concentrate on your work for extended periods of time? Yes X No \_\_\_\_\_  
If no, PLEASE DESCRIBE.
5. Did you have trouble getting along with your supervisors and/or coworkers? Yes \_\_\_\_\_ No X  
If yes, PLEASE DESCRIBE.
6. When changes were made at work that affected your job, were you able to accept these changes? Yes X No \_\_\_\_\_  
If no, PLEASE DESCRIBE.

7. Additional Comments:

I JUST WANT TO BE ABLE TO STAY AT  
HOME + GET WELL AGAIN AND GO BACK TO  
WORK

9-22-96

Date

  
 Signature of Person Completing Form

Relationship to Claimant



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## PERSONAL PAIN QUESTIONNAIRE

1. Describe the location, severity, and nature (sharp, dull, aching, etc.) of your pain.

PAIN IS LOCATED IN ~~L-5, L-4, S-1~~ BACK AND GROIN.  
ANY BENDING OR STANDING, SITTING  
SHARP IN TESTICLES

2. What makes your pain worse (movement, cold weather, etc.)? Is your pain worse in the morning, afternoon, or evening?

PAIN IS ALL THE TIME NO MATTER WHAT

3. How often do you experience pain? Per day/per week? How long does the pain last?

PAIN IS ALL THE TIME NO MATTER WHAT

4. Is your pain located in a specific area or does it radiate (move) into other areas?

GOES FROM BACK (LUMBAR) TO GROIN AREA.  
PAIN IN TESTICLES IS UNBEARABLE

5. Has your pain changed over the last 12 months? If so, how?

HAS NOT BEEN 12 MONTHS ~~STILL~~

6. Are you using pain medication? Yes      No X If yes, what is the name of the medication and the dosage? What is the name, address, and telephone number of the doctor who prescribed the medication?

NOTHING WORKS AND I AM AFRAID OF  
ADDICTION



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7. How does the medication affect the pain? What side effects from the medication do you have?

I AM NOT TAKING PAIN MEDICATION, IT DOES NOT WORK! STOP ASKING ME!!

8. Describe any other treatments that you use to relieve your pain (hot baths, therapy, exercise, etc.). How well do they work?

HAVE TRIED EPIDURAL BLOCKS, PHY. THERAPY  
HOT SHOWERS CANNOT BATHE, ICE PACKS

9. Did you ever attend a chronic pain program? Yes ☒ No ☐  
If yes, when and where?

FITZ MERCY HOSP - DR. KEVIN CAMPBELL  
1500 LANSDOWNE AVE / PHY. THERAPY  
DARBY, PA.

10. Describe the activities that you have had to restrict or stop because of pain.

MY WORKING ABILITIES, ALL RECREATIONAL  
FAMILY CARE, HOUSE DUTIES, ETC.

11. Do you use an assistive device to walk (cane, crutch, etc.)? Yes ☐ No ☒

Are you able to walk without this device? Yes ☐ No ☐  
When did you begin using this device?

What is the name, address and telephone number of the doctor who prescribed this device?

12. Has pain affected the amount of time you sleep? Yes ☒ No ☐  
If yes, please explain how your sleeping habits have changed.

NO SLEEP FOR DAYS AT TIME  
SEE- (DESYREL 100 mg 1-2 AT BEDTIME)  
PER DR. LEE SILVERMAN (FITZ MERCY HOSP PSY. UNIT)





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13. Since your pain began, have your eating habits changed due to the pain?  
Yes ☒ No ☐ Has your weight changed? Yes ☒ No ☐ If yes, by how much?

SO LBS. DUE TO ELAVIL MEDICATION

If there has been a change in either direction, were you trying to change your weight? Yes ☐ No ☒

14. Has your ability to think and concentrate been affected by the pain?  
Yes ☒ No ☐ If yes, please explain.

HAS MADE ME UNABLE TO WORK THUS GO INTO  
MAJOR DEPRESSION

15. Have you ever been referred to a psychologist/psychiatrist to help cope with pain? Yes ☒ No ☐ If yes, please provide name, address, telephone number, and dates of treatment.

DR. LEE SILVERMAN, M.D.  
MEDICAL DIRECTOR INPATIENT PSYCHIATRY  
1500 LANSDOWNE AVE  
PARBY, PA. 19023  
610-237-4122, Fax 610-237-4695

ROSE MARINO, PH.D.  
700 N. JACKSON ST.  
MEDIA, PA 19063  
610-566-4330  
Fax - 610-566-5346

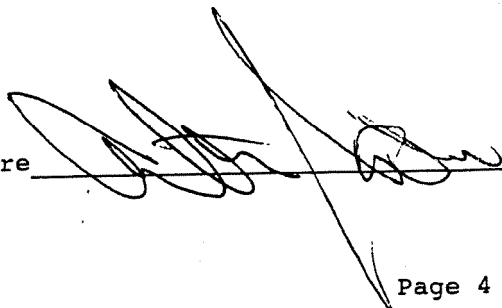
16. Are you able to take care of yourself as far as day-to-day needs are concerned?  
Yes ☒ No ☐ If no, please explain.

HAVE TO BE REMINDER OF CLOTHES CHANGES +  
SHOWERS AND APPOINTMENTS.

17. Please describe your activities for a typical 24 hour day. Please comment on things such as cooking, laundry, shopping, cleaning (vacuuming, dusting, scrubbing), reading, hobbies, car repairs, yard work, exercise, etc.

MICROWAVE COOKING - YES  
NO SHOPPING, CLEANING, HOBBIES YARD WORK  
CAN NOT STAY FOCUSED

Signature



Date

9-22-96



**EXHIBIT S**

Feb 20 03 03:54p

Neurology Associates

215 463 0131

P.C.

Neurology Associates, Ltd.  
1514 Wolf Street  
Philadelphia, Pa. 19145  
(215)463-3029  
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Stephen E. Reznak, M.D.  
Dan Gzesh, M.D.

Lorenzo G. Runk, M.D.  
Debashis Biswas, M.D.

February 4, 2003

John Rollins, Esquire  
1134 Rodman Street  
Philadelphia, PA 19147

RE: Arthur Jackson, III

Dear Mr. Rollins:

As you know, I have been treating Mr. Jackson for a prolonged period time, including prior to his injuries of May 28, 2000.

He currently suffers from the neurological sequelae of a severe head injury. I believe the injury, a subdural hematoma, was related to the deprivation of clonazepam, which he had been receiving on a chronic basis, which led to a seizure and a subsequent head injury.

His neurological prognosis is poor at this time. It is likely that he has obtained maximum neurological improvement and further improvement is unlikely.

There is no therapy available for this condition at the current time.

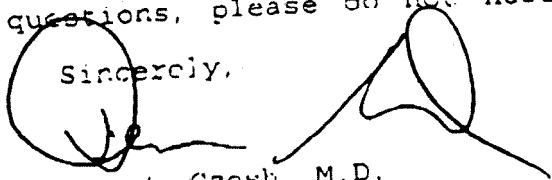
Because of his injury, he has suffered significant cognitive and emotional impairment, including the inability to remember to perform activities of daily living, such as taking his insulin.

I believe the injuries are permanent, a direct result of the accident of May 28, 2000 and that he is incapable of self sufficient living.

All opinions are made with a reasonable degree of medical certainty.

If you have any questions, please do not hesitate to contact me.

Sincerely,

  
Dan J. Gzesh, M.D.

DIG:MDP